

**Massachusetts Department of Public Health
Confidentiality Complaint Form**

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

Please describe the nature of the complaint including dates of occurrence. Please name the DPH program, Bureau, or any individuals involved in your complaint.

Your Signature or Signature of Personal Representative Date

Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information disclosed.

☐ Person signing is the individual

☐ Person signing is the Personal Representative authorized to make health care

decisions for the individual. Describe the authority: _____

Please mail this form to:
Privacy Office
Massachusetts Dept. of Public Health
250 Washington St.
Boston, MA 02108

You may also contact:
Office for Civil Rights
US Dept. of Health and Human Services
Government Center
J.F. Kennedy Federal Building-Room 1875
Boston, MA 02203
Voice Phone (617) 565-1340
Fax (617) 565-3809 TDD (617) 565-1343